fifteen times; he knew the insurance company was to pay the bill.

The following is another marked example: A professional malingerer came to me not long ago as a patient. He came in with a tear in his shirt, dusty coat, etc. Had "just fallen off a street-car and broken two ribs." He gave me a beautiful story, and very good symptoms, too. I examined him carefully, could not locate the broken ribs, but did not say anything at the time. The third day he came to me to sign an application on an insurance company for $400, the amount that was to be paid for two or more broken ribs. I told him I would not sign for two broken ribs because I did not think he had any. He left in great anger; would sue me, the street-car company, and the insurance company. He came back the following day with certificates from five different doctors, stating that he had anywhere from two to four broken ribs. I told him I did not care if he had fifty certificates, I would not sign unless he would have an X-ray picture taken. He settled with the insurance company for $14, instead of $400, because he said he was afraid of the X-ray.

I do not question that many doctors of Los Angeles have signed applications for money on the insurance companies that they (the doctors) themselves felt were unjust, yet they felt they had to do it or lose a patient or a fee. Should that not be called a legalized hold-up?

Doctors, as a rule, are rated as a class by the layman; therefore, those that will stoop to the aforesaid irregularities give a black eye to the whole profession. Why can we not have an active "grievance committee" that would chastise the man that renders the unreasonable high bill as well as the one that agrees to work for thirty cents and grafts the rest? I think that if the Los Angeles County Medical Association would handle irregularities of all kinds, as do the Los Angeles County Bar Associations, that a higher standard would soon be maintained. Much credit is due our Secretary for the hard work he has done to bring our Society to its present standing and efficiency.

It has been said, "In Union There Is Strength," and it is my opinion that if we would combine our activities and influence, and manifest a mutual interest in the protection of others, as well as the upbuilding of our present Society, we would soon put our Association on a business basis that would be a great factor for the betterment and strength of our profession of the future.

SOME PRINCIPLES GOVERNING THE INDICATIONS FOR CAESAREAN SECTION.*

By ALFRED BAKER SPALDING, M. D., San Francisco.

Good results can be obtained in abnormal obstetrics if sufficient attention is given to the patient during pregnancy, and if the patient is confined by a competent physician in a hospital devoted exclusively to obstetrics. Well conducted maternity hospitals are able to maintain a maternal mortality of a fraction of one per cent., a fetal mortality of less than five per cent. and a general morbidity rate of under fifteen per cent. This is an important point to consider in discussing the indications for such a valuable operative procedure as is Caesarean section because the relative values of all obstetrical operations are based upon experience obtained in such perfected institutions.

It is unfortunate but true that the great majority of women must be confined by midwives or by very busy general practitioners for very small fees, so small that it does not pay the general practitioner to train especially for obstetrics or to give unusual care to the individual patient. However, as many women deliver themselves safely, the attendant learns to interfere as little as possible with his normal confinements at the time of labor.

When labor is protracted, or convulsions occur, or the cord is prolapsed, or serious hemorrhage starts, then the attendant is in danger of making a bad matter worse by efforts to accomplish a rapid delivery. He does not, as a rule, treat his obstetrical patients with the same consideration that he gives to his other surgical patients. He attempts to perform operations which are well known to entail risk to both mother and baby, amidst the worst possible surroundings, with meager equipment and with insufficient assistants. One thing only impels him to send his patient to a hospital and place her in the care of a better trained accoucheur and that is the absolute impossibility for him to drag by physical force the child from the maternal passages.

Besides the obstetrician and the general practitioner, there is a third attendant who attends to a considerable number of confinements, although he rarely speaks of his attentions. This is the surgeon practitioner. With this type of attendant, the patient is usually saved unnecessary examination or injury from forceps for the attendant does not claim either unusual diagnostic acumen or obstetrical skill. When emergencies arise, demanding interference, he often plays his one trump card—Caesarean section.

To discuss the indications for Caesarean section, it is necessary to consider not only the pathological condition present and to compare the relative values of Caesarean section with other time-honored operations, but one must take into consideration the type of attendant who is called upon to meet the situation. Judgment is needed to determine not only when the operation is indicated, but also if conditions justify it. An operative crust should not overflow the diagnostic pan.

For instance, in the case of moderate contraction of the pelvic outlet, either in the bi-ischial diameter or in the posterior sagittal diameter, with the child presenting by the breech, the general practitioner may be forced to do a craniotomy on the aftercoming head because he fails at the opportune time to diagnose the condition; the surgeon may do a needless Caesarean section while an obstetrician might meet the condition by placing prophylactically a pubiotomy saw.

It is easy to quote a list of indications for the operation of Caesarean section. One reads of the relative and absolute indications in cases of pelvic

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contraction, of eclampsia, placenta previa, prolapsed cord, breech presentation, tumor formation, heart and kidney disease, Boston disease, and previous Caesarean section. My own experience is not great enough to permit me to express myself with assurance upon the relative values of this list of indications; nevertheless, it will probably prove more interesting to base my inferences upon this experience, meager though it is, than to quote from literature you have probably already read.

In reviewing my records in preparation for this paper, I find that I have operated myself or have assisted others with this operation in twenty-five instances. In every case there existed a grave danger for the mother or child which was met successfully, so far as all the mothers were concerned, by the Caesarean operation, and yet in some instances, I am convinced delivery could have been accomplished by other procedures. To discuss the indications, these cases will be placed in groups according to the frequency of occurrence.

Most frequent are the patients with pelvic disproportion. In routine examination of private and hospital patients, I have met with contracted pelvis, over a series of seven hundred confinements in a little less than 10%, but have seen in this series only two patients with a true conjugate of 7½ cm. or less. With one of these Caesarean section was most satisfactory, while with the second an attempt at premature labor was fatal for the child and caused a severe laceration in the mother. In two consultations, this serious degree of contraction was met with twice. In one case, the Caesarean operation gave perfect results; in the second case, the condition was overlooked until the patient was in a most serious state as a result of several hours of anesthesia and protracted attempts at high forceps delivery. A most difficult craniotomy and extraction resulted in a complete laceration of the perineum.

Ten Caesarean sections were performed for moderate degrees of pelvic contraction. In four cases the operation was performed with perfect results to both mother and baby after severe test of labor had failed to cause the head to engage. I have always made it a rule to have patients with moderate degrees of pelvic contraction undergo a good test of labor unless some other condition besides the pelvic contraction existed to indicate operation. With one patient in the above group, after two days of ineffectual labor the presentation changed spontaneously from vertex to breech and the Caesarean section followed. This patient subsequently delivered herself spontaneously of a living child. Patients delivered with forceps or version after a test of labor have not given satisfactory results. I am convinced that uncomplicated patients with moderate degrees of pelvic contraction should undergo a test of labor, if they can be protected against infection during the test, as by far the larger number will deliver the head into the cavity of the pelvis. But when the test fails, I believe resort should be had to Caesarean section if the patient is in competent hands, or resort to craniotomy should be had if the patient is in the hands of an inexperienced operator.

The six cases of doubt in which no test of labor was carried out were complicated as follows: One patient gave a history of previous loss of child by high forceps; two patients had had previous Caesarean section; one patient was an old primipara with an ankylosed hip; one patient was an old primipara with an outlet contraction; one patient was a rachitic, debilitated dwarf with chronic nephritis. All the mothers of the above series recovered but the baby of the rachitic dwarf died shortly after the operation.

There were four Caesarean sections because of pelvic tumor. One was a simple parovarian cyst that, had an accurate diagnosis been possible, could have been left alone to rupture, probably without danger to the patient. One was for fibroid of the uterus in a patient who had lost one child because of the tumor and who requested a Caesarean at term with myomectomy and resection of the fallopian tubes. One was for fibroid with a history of previous Caesarean section and one was for a massive hematoma which developed suddenly during the course of a normal labor. The operation was successful for all these mothers and their babies. The last patient subsequently gave birth spontaneously to a live child, but suffered later in a third confinement with spontaneous rupture of the uterus. It is needless to state that all patients who have once had a Caesarean section require most careful watching in subsequent labor and not infrequently need a second Caesarean section for no other reason except that the uterus is weakened with scar tissue.

Three patients have been operated on because of placenta previa. All were primipara and all were saved their babies without serious injury to themselves. In my experience with placenta previa, I have never lost a mother but have not saved one-half of the viable infants by resort to version, for which reason I am in favor of recommending Caesarean section in suitable cases of placenta previa. Two patients with broken compensation from serious endocarditis and one patient with great edema of legs, vulva and abdomen were operated. The mothers all survived and the two viable children were saved. One baby died of immaturity as the operation was performed for broken compensation at the sixth month.

Of the remaining three cases, one was operated by my interne during my absence, for eclampsia. One was operated in consultation for serious toxemia resulting from several weeks of pernicious vomiting because of the need for rapid delivery, and because the attendant was an expert abdominal surgeon with insufficient confidence in a vaginal operation. One Caesarean was performed for the sole indication that a previous Caesarean had been done and labor was becoming protracted. No indication for the previous Caesarean could be ascertained. Of these three patients, all recovered and one baby was delivered alive and well. The other two babies, one from the eclampsia patient and one from the pernicious vomiting, were both born dead.

This completes my experience with Caesarean section. The list of indications is quite varied and the results have been satisfactory. In obstructed labor, the judging of indications is not very dif-

Summary:

No. Cases.....	Indication	Time of Operation	Mortality of child.....	Mortality of mother...
2	Con. Pelvis T. C. 7½	Before labor started	0	0
4	Con. Pelvis Mod.	After prolonged test of labor	0	0
1	Con. Pelvis Mod. Loss of 1st baby by forceps	Before labor started	0	0
2	Con. Pelvis Mod. Previous Caesarean	Before labor started	0	0
1	Con. Pelvis Mod. Old primipara	Before labor started	0	0
1	Con. Pelvis Mod. Outlet contraction	Before labor started	0	0
1	Con. Pelvis Mod. Chronic Nephritis	Before labor started	1	0
1	Parovarian Cyst	First stage labor	0	0
2	Fibroid Uterus	Before labor started	0	0
1	Large Pelvic Hematoma	After prolonged labor	0	0
3	Placenta Previa	First stage labor	0	0
1	Endocarditis Broken compensation	Sixth month Pregnancy	1	0
1	Endocarditis Broken compensation	Last month Pregnancy	0	0
1	Toxaemia with massive oedema vagina and perineum	At onset of labor	0	0
1	Eclampsia	First stage labor	1	0
1	Pernicious vomiting	Fifth month Pregnancy	1	0
1	Previous Cesarean Section	First stage labor	0	0

Total, 25.
Mortality viable babies, 9%.
Mortality mothers, 0%.

ficult but necessarily requires great patience. In serious hemorrhage from placenta previa or accidental hemorrhage, rapid judgment is needed and much depends upon the operator. One must not place too great risk upon the mother without first considering carefully the excellent record of Braxton Hick's version.

It requires careful judgment, which can be obtained only by treating many patients, to decide individual cases of placenta previa just the best method of procedure that will give the best results to mother and child. There is no doubt, however, that in some varieties of placenta previa, good operators can obtain their best results by recourse to Caesarean section.

In general, mechanical conditions which endanger the life of the child, as well as non-infectious conditions which weaken the uterine muscle or strain the maternal heart, offer indications that one must consider in thinking of Caesarean section. So long as infection does not complicate the condition, Caesarean section is a most valuable operation but in the presence of infection or in doubtful cases where the danger of subsequent infection is a probability, Caesarean section has only a limited field. Toxic conditions such as eclampsia, pernicious vomiting and nephritis usually influence the child so badly and the lowered resistance of the patient so often precedes infection that these conditions can only rarely be considered to indicate Caesarean section.

There is no doubt that the sphere of indications for Caesarean section is growing and there is considerable danger that the pendulum will swing too far toward the operative side. It should not be forgotten that even in good hands the operation carries with it a maternal mortality in the neighborhood of five per cent., or ten times the maternal mortality obtained in confinements generally.

HYGIENIC SHOEING—ANATOMICAL FACTS VS. CONVENTION AND STYLE.*

By C. C. CRANE, M. D., San Francisco.

The evidence to be submitted consists, in the main, of four facts:

(1). In the examination of the feet of one thousand adult Puerto Ricans, who had never worn shoes, virtually not one presented evidence of foot-illness or deformity.

(2). In the examination of the feet of one thousand individuals, who have worn shoes for a considerable period of time, and in whom the feet are not troublesome—that is, are symptomless—it is rare to find a foot that is in normal condition.

(3). A very large percentage of shoe-wearing people present evidence of foot trouble which is promptly relieved by shoeing in accordance with anatomical facts.

(4). After a canvass of practically all of the local shoe stores, the hygienic shoe is found to be conspicuously infrequent.

In virtue of these observations, is it at all surprising or remarkable to note the amount of foot-trouble which is so prevalent as to deserve to be called endemic! The claim that every foot-ill is due to faulty shoeing is not made. The claim that every foot which is unanatomically shod gives rise to subjective or objective evidence of abuse is not

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